FACE INVESTIGATION

SUBJECT: Farmer dies 2 months following a 10 foot fall from a hay wagon

SUMMARY:

A 68 year old white male farmer who had spent his life on the family farm, died as the result of a fall from a hay wagon. The farmer and his wife were loading a small hay wagon with baled hay which they were going to take into the field feeding area. The farmer was on the stacked bales (about 10 feet high) when he slipped or fell forward to the concrete barnyard. Conditions were dry, cold and sunny, it was approximately 9AM. The victim's wife was helping him but did not witness the incident as she had gone into the barn. The victim was taken to the hospital where he was admitted and died 2 months later. The Wisconsin FACE investigator concluded that, in order to prevent future similar occurrences, the employer should:

! Develop, implement, and enforce a comprehensive safety program that includes but is not limited to a survey of the worksite to identify hazards and training in fall hazard recognition.

! Consider and address worker safety in the planning phases of all projects.

INTRODUCTION:

At 9 AM on December 26, 1991 a 68 year old farmer fell approximately 10 feet from bales loaded on a small wagon to a concrete walkway striking his head. The Wisconsin Face investigator was notified by the Wisconsin Department of Industry Labor and Human Relations, Workers Compensation Division on April 6, 1992. The death certificate was the only report received. A site investigation was made on January 7, 1993. Photographs were taken of the concrete walkway and the wagon that was used the day of the incident. The farmer's wife, who had been helping but did not see the fall, was interviewed. The farmer's wife reported that a second fall ocurred in the hospital. The University Department of Agricultural Engineering was asked to review the factors that lead to this death with the FACE director and provide assistance with developing preventive stategies.

The victim had farmed on this site for 61 years. According to the victim's wife the victim was the full time safety officer and safety was an important issue for both of them. There were no written safety rules and no discussion about safety had been held prior to the hay loading task which they did every morning in the same way.

INVESTIGATION:

On the morning of December 26, the victim and his wife had loaded the wagon with bales of hay. The wagon bed was approximately 6'x10' and was equipped with 1 foot side panels on both sides. According to the wife, her husband had stacked the bales about 10 foot high and that he was probably climbing down

when he slipped and fell forward onto the concrete walkway where she found him. The day was cold, dry, and sunny. The victim was transported to the hospital where he remained until his death February 13, 1992.

CAUSE OF DEATH: Brain stem failure (possible stroke or infarct), intracerebral hemorrhage, closed head injury.

RECOMMENDATIONS/DISCUSSION:

Recommendation #1: Employers should develop, implement and enforce a comprehensive written safety program. The written program should include but not be limited to a hazard evaluation and a training program that would address the recognition of fall hazards and eliminate them when possible.

Discussion: In this case, the fall may have been prevented by installation of a ladder on the wagons for easy and safer climbing along with higher side panels (staff members of the UW Department of Agricultural Engineering indicate that wagons with sides are not always practical for the farmer's tasks).

Recommendation #2: Consider safety in the planning stages of all work projects.

Discussion: In this instance planning the safest way to move the bales may have prevented this incident. The plan could have included using a different wagon with sides and/or making several trips to the field so that there were less bales on the wagon producing more stability, less height, less reason to climb up onto the wagon.